Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

April 19, 2023

, CHIEF OPERATING OFFICER
GAHC3 YORK PA ALF TRS SUB LLC

RE: SENIOR COMMONS AT POWDER MILL
1775 POWDER MILL ROAD
YORK, PA, 17403
LICENSE/COC#: 33210

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/15/2023, 02/16/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SENIOR COMMONS AT POWDER MILL* **License #**: *33210* **License Expiration**: *01/18/2024*

Address: *1775 POWDER MILL ROAD, YORK, PA 17403*

County: *YORK* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*

Address:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *07/23/2001* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *131* **Waking Staff**: *98*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/16/2023*

Inspection Dates and Department Representative

02/15/2023 On Site:

02/16/2023 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served**: *100*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Gardens* **Capacity**: *28* **Residents Served**: *22*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *100*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *31* **Have Physical Disability**: *1*

Inspections / Reviews

02/15/2023 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/09/2023*

Inspections / Reviews *(continued)*

03/17/2023 POC Submission

Submitted By: [redacted]
Date Submitted: *03/31/2023*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *03/24/2023*

03/27/2023 POC Submission

Submitted By: [redacted]
Date Submitted: *03/31/2023*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *04/01/2023*

04/12/2023 Document Submission

Submitted By: [redacted]
Date Submitted: *03/31/2023*
Reviewer: [redacted]
Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], Resident # 1 had a fall and was sent to the hospital via ambulance. The fall resulted in a hip fracture requiring surgery and a five-day hospital stay. The home did not report this incident to the Department.

Plan of Correction ***Accept ([redacted] - 03/27/2023)***

What: On [redacted] Resident # 1 had a fall and was sent to the hospital via ambulance. The fall resulted in a hip fracture requiring surgery and a five-day hospital stay. The home did not report this incident to the Department.
Who: The Assistant Executive Director will review incidents as they come in and follow up with those residents as they are sent out for evaluation.
When: During the annual inspection, it was discovered that this injury was not reported due to questions coming from discrepancies in the final incident report for the residents death. An internal incident report was discovered (for the hip fracture on [redacted]) at the time of the annual inspection but it was not sent to DHS.
How: Executive Director will train the Assistant Executive Director and Memory Care Director on incidents requiring a report to DHS. Training will be completed by 3/13/23.
Ongoing: The Assistant Executive Director will continue to monitor when residents are sent out to the hospital on an ongoing basis to ensure that ongoing compliance is maintained and repeat issues do not occur. Only the Executive Director, Assistant Executive Director and Memory Care Director send reportable incidents at this time but as any future members of the community team are trained or added to the Designee role, they will receive the same oral training from the homes Administrator on the homes procedures. Any concerns or issues will be reviewed at the quarterly quality assurance meeting.

UPDATE: Incident report submitted by Executive Director [redacted] on 3/24/23 for 7/31/22 incident requiring reporting to BHSL.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 04/03/2023)

109b - Rabies Vaccination

2. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On [redacted], Resident # 2's cat named "Buddy" was present at the home. The home does not have a current certificate of rabies vaccination for "Buddy". The most recent rabies vaccination the home had, expired on [redacted].

Plan of Correction ***Accept ([redacted] - 03/27/2023)***

What: On 2/15/23, Resident # 2's cat named "Buddy" was present at the home. The home does not have a current

109b Rabies Vaccination (continued)

certificate of rabies vaccination for "Buddy". The most recent rabies vaccination the home had, expired on 12/29/22.
Who: The Business Office manager contacted the resident family and they scheduled an appointment to have the cat vaccinated. The resident family decided to remove the cat.
When: Buddy left the community on 2/17/23 and did not return. First audit to be completed by 4/1/23 and will be completed monthly in an ongoing basis.
How: Business Office Manager will use (Vaccination Tracker) to ensure all pets annual vaccinations are up to date and new admission vaccinations are up to date.
Ongoing: Business Office Manager to collect vaccination records upon move in and keep track of vaccination records using (Vaccination Tracker). Business Office Manager will review all pet records monthly. This includes all pets that live in the home and any visiting with families or for therapy purposes. Findings will be reviewed at the quarterly quality assurance meeting.

UPDATE: Ongoing step started on 2/17/23 when "Buddy" was removed from the community as the only pet without vaccination records on hand. Began checking monthly records on 2/17/23

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented - 04/03/2023)

141a - Medical Evaluation

3. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The medical evaluation dated for Resident # 3, who was admitted to the home on was not completed within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction ***Accept (- 03/27/2023)***

What: The medical evaluation dated for Resident # 3, who was admitted to the home on was not completed within 60 days prior to admission or within 30 days after admission of the resident.
Who: The Assistant Executive Director will use the 30 Day Chart Audit Tool to ensure residents DME is completed within the required window of time.
When: Resident is scheduled to be seen by his PCP on 4/10/23 for his annual medical evaluation.
How: The Assistant Executive Director will use the 30 Day Chart Audit Tool to ensure the medical evaluation form is completed within 60 days prior to admission or within 30 days after admission
Ongoing: The Assistant Executive Director will use 30 day chart audit tool to audit resident charts within 30 days after admission. Findings will be reviewed at the quarterly quality assurance meetings. A monthly sample of resident records will be reviewed for quality assurance.

UPDATE: Monthly Audit of resident record sample to being on 4/1/23

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented (- 04/03/2023)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # 4's most recent medical evaluation was completed on [redacted]. As of [redacted], this resident has not had a medical evaluation within the past year.

Plan of Correction ***Accept ([redacted] - 03/27/2023)***

What: Resident # 4's most recent medical evaluation was completed on [redacted] As of [redacted], this resident has not had a medical evaluation within the past year.

Who: The Assistant Executive Director will utilize the Forms Due-2 report from TabulaPro to track resident medical evaluations needing to be completed.
When: Resident #4 medical evaluation completed on [redacted] Monthly audit will be completed of resident records to ensure medical evaluations are completed within the required timeframe starting on 4/1/23.
How: The Assistant Executive Director will assure a new medical evaluation is completed at least annually.
Ongoing: The Assistant Executive Director will use the Tabular Pro Forms Due-2 Report and the 30-day chart audit tool to ensure resident most recent medical evaluation is completed. Findings will be reviewed at quarterly quality assurance meetings. A monthly sample of resident records is reviewed for quality assurance.

UPDATE: Monthly Audit of resident record sample to being on 4/1/23

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented ([redacted] - 04/03/2023)

183b - Meds and Syringes Locked

5. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

Resident #5 is assessed to self-administer certain medications that are prescribed to them. On [redacted] at [redacted], two tubes of [redacted] were observed unlocked, unattended, and accessible in Resident #5's bathroom cabinet, the label indicates "Apply Topically to areas of skin irritation three times a day". Resident #5's DME dated [redacted] indicates resident cannot self-administer this medication.

Plan of Correction ***Accept ([redacted] - 03/27/2023)***

What: Resident #5 is assessed to self-administer certain medications that are prescribed to them. On [redacted] at [redacted], two tubes of [redacted] were observed unlocked, unattended, and accessible in Resident #5's bathroom cabinet, the label indicates "Apply Topically to areas of skin irritation three times a day". Resident #5's DME dated [redacted] indicates resident cannot self-administer this medication.
Who: The Assistant Executive Director will train the wellness staff what to do when medications or topical ointments are found in residents rooms
When: Training to be completed by 3/31/23

183b Meds and Syringes Locked (continued)

How: Assistant Executive Director educate the wellness team using the Best Practices Walking Rounds at shift change to ensure medications were not brought in or left in the room during the shift.
Ongoing: Staff to report to Assistant Executive Director when medications are found in resident rooms. Findings will be reviewed at the quarterly quality assurance meeting

UPDATE: Assistant Executive Director, removed the from the residents room on 2/16/23.
Weekly audit of resident rooms to check for medications completed by housekeeping department. Training of Housekeeping staff on what to be aware of regarding medication in resident rooms to be completed by 3/31/23. Weekly audit of resident rooms to start on 3/31/23 by housekeeping and run for 6 weeks. Carestaff will be trained and vigilant on what to look out for regarding medications when entering resident rooms

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented (- 04/10/2023)

185a - Implement Storage Procedures

6. Requirements

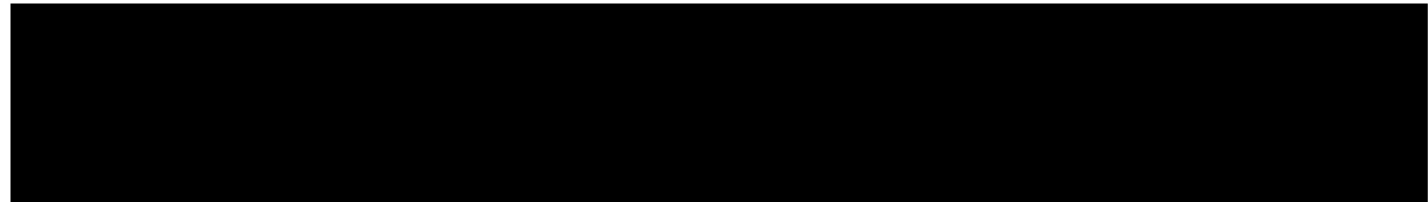
2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #6 is prescribed hour tab as needed. On all four of the above medications were not available in the home.

Plan of Correction ***Accept (- 03/17/2023)***

What: Resident #6 is prescribed and as needed. On all four of the above medications were not available in the home. Resident # 7 is prescribed of with dinner. Resident is also prescribed additional HumaLOG with meals on a sliding scale three times per day according to the following scale: 151 200 2 units, 201 350



Who: The Assistant Executive Director will use the medication cart audit tool to review with the shift supervisors who will audit one cart each (weekly). Additionally, the Assistant Executive Director will train all Med Techs on the Med Tech shift change responsibility using Med Tech Shift Change Responsibility form to ensure correct insulin is logged in the resident electronic medical record and Diabetic Resident Audit. The Medication Administration trainer will train the staff member who logged the insulin incorrectly on the correct way to document insulin given.
When: Med Tech Shift Change Responsibility training will be completed by 3/31/23. Staff member education on incorrect insulin documentation was completed by 2/24/23.
How: The Assistant Executive Director will train the Med Techs on the process of searching for a medication in the medication cart using the Best Practices Manual Medication Not Available to Give process.
Ongoing: The Assistant Executive Director will review the medication cart audit form monthly and the shift

185a - Implement Storage Procedures (continued)

supervisor will review the Med-Tech shift change responsibility form after each shift. Shift supervisors or Med-Tech will contact resident PCP for refill of medication. Findings will be reviewed at the quarterly quality assurance meetings.

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented - 04/10/2023)

7. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident # 7 is prescribed with dinner. Resident is also prescribed additional HumaLOG with meals on a sliding scale three times per day according to the following scale:

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Plan of Correction ***Accept - 03/17/2023)***

What: Resident #6 is prescribed , and as needed. On all four of the above medications were not available in the home. Resident # 7 is prescribed 12 units of with dinner. Resident is also prescribed additional

Who: The Assistant Executive Director will use the medication cart audit tool to review with the shift supervisors who will audit one cart each (weekly). Additionally, the Assistant Executive Director will train all Med-Techs on the Med-Tech shift change responsibility using Med-Tech Shift Change Responsibility form to ensure correct insulin is logged in the resident electronic medical record and Diabetic Resident Audit. The Medication Administration trainer will train the staff member who logged the insulin incorrectly on the correct way to document insulin given.
When: Med-Tech Shift Change Responsibility training will be completed by 3/31/23. Staff member education on incorrect insulin documentation was completed by 2/24/23.
How: The Assistant Executive Director will train the Med-Techs on the process of searching for a medication in the medication cart using the Best Practices Manual – Medication Not Available to Give process.
Ongoing: The Assistant Executive Director will review the medication cart audit form monthly and the shift supervisor will review the Med-Tech shift change responsibility form after each shift. Shift supervisors or Med-Tech will contact resident PCP for refill of medication. Findings will be reviewed at the quarterly quality assurance meetings.

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented (- 04/10/2023)

187d - Follow Prescriber's Orders

8. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #8 is prescribed 1 packet of . However, this medication was not administered to Resident #8 in the morning of because the medication was not available in the home.

Resident #8 is also prescribed daily. However, this medication was not administered to Resident #8 at bedtime on because the staff person "could not find it in the cart".

Plan of Correction ***Accept (- 03/27/2023)***

Who: The Assistant Executive Director will train the Med-Techs on the Best Practices Manual – Medication not available process.
When: Training to be completed by 3/31/23
How: The Med Techs will follow the steps in the Best Practice Manual – Medication not available as medications are not in the cart for distribution or able to be found in the cart
Ongoing: The shift supervisors will conduct a weekly Medication Cart Audit to check that residents medication is available in cart and the medication carts are organized. All standing order medications will be delivered as part of the monthly cycle fill. If standing order medications are not available to be given, the shift supervisor or Med-Tech will contact the PCP. Findings will be reviewed at the quarterly quality assurance meetings.

UPDATE Medication cart audit to begin on 3/6/23

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented - 04/10/2023)

190a - Completion Medication Course

9. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff persons B hired on and C hired on have no record of successfully completing the Department-approved medications administration course that includes the passing of the Department's performance-based competency test, have been administering medications to residents on a daily and consistent basis.

190a Completion Medication Course *(continued)*

Plan of Correction ***Accept (- 03/27/2023)***

Who: The Medication Administration trainer will audit the medication administration binder by 4/1/23 using (DHS Medication Administration Forms) for initial test/MAR Review/Observations and quarterly practicum observations. Primary Medication Administration Trainer, was out on Maternity leave during time of inspection. Current Executive Director present during completion of original medication administration course for staff persons B & C, which were missing at time of survey. MAR Reviews and practicum observations were present during time of survey. No performance issues or medication errors noted at time of survey for either staff member. Med Techs will be observed by secondary Medication Administration Trainer, by 4/1/23 and given re examination by 4/1/23.
When: Medication Administration audit will be completed by 4/1/23 and audit will be completed monthly moving forward.
How: Medication Administration trainer will utilize DHS Medication Administration Forms to complete full Med Tech audit.
Ongoing: All Med Tech forms will be saved in employee charts in TabulaPro. Med Tech Practicum Observations dates tracked by Medication Administration Trainer using (Training Tracker). Findings to be reviewed at the quarterly quality assurance meeting.

UPDATE Medication Observations to begin 4/1/23

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented - 04/10/2023)

224a - Preadmission Screen Form

10. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #8 was admitted to the home on ; however, the resident's preadmission screening form was completed on .

Plan of Correction ***Accept - 03/17/2023)***

What: Resident #8 was admitted to the home on ; however, the resident's preadmission screening form was completed on .
Who: The Assistant Resident Care Director will utilize the Pre Admission Screening form for every new resident move in or Personal Care to Memory Care transfer. The Assistant Executive Director will meet with the admission team upon each admission to the community to review the pre admission screening. No admission dates will be planned without having all admission documents in the record.
When: Upon each new move in or internal transfer
How: The Assistant Executive Director utilize the Pre Admission Screening form for every new move in or internal transfer. The admissions team will use the Move In Checklist to ensure all pre admission documentation is complete prior to resident arriving in community.
Ongoing: The Assistant Executive Director will complete a Monthly audit of preadmission screen forms (Starting on 3/6/23) for all residents who moved into the community that month. Findings and trends will be reviewed at the QA meetings.

224a Preadmission Screen Form (continued)

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented - 04/10/2023)

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #7's current assessment was completed on However, the resident's previous assessment was completed on .

Plan of Correction ***Accept - 03/27/2023)***

What: Resident #7's current assessment was completed on . However, the resident's previous assessment was completed on .
Who: The Assistant Executive Director will use the 30 Day Chart Audit Tool and TabulaPro Forms Due 2 Report to ensure residents annual assessments are completed within the necessary window.
When: Monthly audit completed of resident record sample using Forms Due 2 Report monthly to ensure all documents are present in the record and updated.
How: The Assistant Executive Director will review the Forms Due 2 Report monthly. This will ensure accuracy of resident assessments being completed within the required timeframe. The Forms Due 2 report is used to track when forms are due, so they can be planned to be completed prior to the due date.
Ongoing: The Assistant Executive Director will pull the Forms Due 2 Report from TabulaPro and complete resident assessments within the required window. Findings will be reviewed at quarterly quality assurance meetings.

UPDATE Forms Due 2 Report audit started 3/6/23

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented - 04/10/2023)

227g -Support Plan Signatures

12. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #7's most recent support plan dated did not include either a signature of the resident nor an indication that the resident was either unwilling or unable to sign.

Plan of Correction ***Accept - 03/27/2023)***

What: Resident #7's most recent support plan dated did not include either a signature of the resident nor an indication that the resident was either unwilling or unable to sign.
Who: The Executive Director will train the Assistant Executive Director on how to capture signatures on the RASP in TabulaPro. The Assistant Executive Director will use the 30 day chart audit tool to check resident support plans and

227g Support Plan Signatures (continued)

ensure signatures or indication that the resident was either unwilling or unable to sign support plan
When: Executive Director will complete training of Assistant Executive Director by 3/10/23
How: The Assistant Executive Director will ensure new resident support plans are marked that resident signed or it was noted that resident was unable or unwilling to sign. Assistant Executive Director will review the Forms Due 2 Report weekly with the Clinical Care Coordinator.
Ongoing: Assistant Executive Director will utilize TabulaPro Forms Due 2 report to track when support plans are scheduled to be completed for new residents and audit appropriate charts for completion.

UPDATE Resident unable to sign RSAP on [redacted] and that is indicated on RASP.
Forms Due 2 Report audit started 3/6/23

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented [redacted] - 04/10/2023)

233c - Key-Locking Devices

13. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The Secure Dementia Care Unit (SDCU) in Rosewood Court has a courtyard with two gates leading from the courtyard to the exterior yard. The right side gate (from the courtyard) did not open when the correct code was entered. It was later discovered that the bottom row of buttons would not function, and the gate door remained locked and unavailable for egress.

Plan of Correction ***Accept ([redacted] - 03/27/2023)***

What: The Secure Dementia Care Unit (SDCU) in Rosewood Court has a courtyard with two gates leading from the courtyard to the exterior yard. The right side gate (from the courtyard) did not open when the correct code was entered. It was later discovered that the bottom row of buttons would not function, and the gate door remained locked and unavailable for egress.

Who: The Maintenance Director will have the keypad repaired by 2/28/23. There are two exits in the courtyard and the other exit was operable at time of survey.

When: Corrected on 3/3/23. Maintenance Director will audit the gate reader keypad to exit the memory care neighborhoods monthly starting on 4/1/23.

How: Maintenance Director contacted [redacted] on 2/16/23 (alarm monitoring company) to repair the keypad.

Ongoing: Maintenance Director to use weekly audit form (Secure door Tracker) to check all locking door keypads and ensure they disengage when code is entered. Findings to be reviewed at the QA meetings.

UPDATE Maintenance Director started weekly audit of maglocks on 2/27/23

233c Key Locking Devices (continued)

Licensee's Proposed Overall Completion Date: *04/01/2023*

Implemented ██ - 04/12/2023)